

important link in this lymphatic chain and is the situation in which organisms are most consistently found in cases of ascending infection. In early cases of lymphatic infection of the kidney no organisms are found in the urine. There are reasons to believe that a tuberculous infection of the kidney may take place along a route precisely similar to that followed by pyogenic organisms.

**Gastric Syphilis.**—GALLOWAY (*Brit. Med. Jour.*, February 11, 1922, p. 217) says that there are two symptoms and three signs. The symptoms are, first, anorexia—no other condition shows this so absolutely excepting in some early cases of malignant disease, and secondly, the nature of the pain. The signs are, first, enlargement of the liver (and occasionally also of the spleen) with smooth outline, present in three-fourths of all the cases; secondly, rapid development of cachexia; and thirdly, stigmata of syphilis. The real test is the empiric, the therapeutic, and that may be applied both from its negative and positive aspects. The change is immediate upon specific treatment, while the result is *nil* upon mere careful arrangement of diet and usual drugs.

**Nature and Cause of Old-age Enlargement of the Prostate.**—WALKER (*Brit. Med. Jour.*, February 25, 1922, p. 297) says that it is impossible to explain enlargement of the prostate by any theory of chronic inflammation alone. Although the enlargement may reproduce conditions favorable to the development of a neoplasm, the enlargement itself does not come into the category of true tumors. The condition is in the nature of a fibroepithelial degeneration which finds its analogy in the female in serocystic disease of the breast. This degeneration may be regarded as an accident occurring during the progress of involution of the genital tract. The cause that determines the onset of the condition is unknown, although it is not improbably connected with a loss of endocrine balance occurring during this period. Prostatic enlargement shows a definite distribution that is anthropological rather than geographical in character. It very rarely occurs among Mongolians and negroes.

**Anomalous Abdominal Membranes.**—TAYLOR (*Ann. Surg.*, 1922, 75, 513) says that anomalous membranes are present in from 15 to 20 per cent of newborn infants. They result from atypical peritoneal fusion during fetal life. Many of them are probably modified by later pathological changes due to continued traction, irritation or low-grade inflammation. They occur in the hepatoduodenal region, at the duodenojejunal angle and about the cecum, ascending colon, hepatic flexure and beginning transverse colon. They cause mechanical disturbances, fixation, angulation, compression and torsion of the digestive tract, resulting in partial, continuous and often increasing obstruction. This, in turn, frequently causes dilation proximal to the obstruction. Symptoms result when the obstruction becomes greater than the peristaltic efficiency can easily overcome, independently of time of life. The symptomatology consists of digestive disturbances, general nutritional disturbances and nervous debility. There are usually tender spots in the mid-epigastrium, over the appendix, over cecum and ascending colon and over the duodenojejunal angle, depending upon the

presence of the various lesions. Examination of gastric contents and stools gives no evidence of value as a rule. Good series of plates from barium gastrointestinal studies are likely to show hepatoduodenal membranes, duodenojejunal angle obstructions and pericolic membranes.

**Clinical Aspects of Abdominal Tuberculosis.**—MORLEY (*Brit. Med. Jour.*, March 11, 1922, p. 383) says that pain, when it occurs in recurrent, well-defined, colicky attacks, especially if they return with regular periodicity and sharp intensity, signifies a mechanical interference with intestinal peristalsis and this can be relieved only by operative measures. Glandular masses in the mesentery, if not too extensive and if they do not yield rapidly to constitutional treatment, should be excised and this is particularly urgent when they are associated with colicky attacks of pain. Palpable masses in the ileocecal region associated with signs of chronic intestinal obstruction are an emphatic indication for laparotomy and resection of the tuberculous ileocecal region should such be found. The ascitic form of tuberculous peritonitis is essentially a disease for surgical treatment. The operation is free from danger and its beneficial results are usually dramatic. Finally, in the plastic type of tuberculous peritonitis, if the trouble does not yield to the ordinary medical measures, operation may be undertaken with a fair degree of safety provided that no extensive attempt is made to separate adhesions and there is some ground for hoping that even these apparently desperate cases may make a complete recovery.

**The Treatment of Surgical Tuberculosis with the Carbon-arc Lamp.**—SAUER (*Ann. Surg.*, 1922, 75, 400) says that the treatment consists in placing the patient before the light and exposing the affected part and as much of the surrounding area of the body as possible. About eight to ten hours after the first treatment a deep erythema is noticed. It is as effective as the natural sunlight and has the advantages of convenience and independence of the weather. It is just as effective, if not more so than the roentgen ray without the attendant dangers. It is far more effective than the quartz-mercury vapor lamp, as has been amply demonstrated by Reyn.

**Tuberculous Abscesses of the Chest Wall.**—AUCHINCLOSS (*Ann. Surg.*, 1922, 75, 406) says that tuberculous abscesses of the chest wall are frequent enough to be of importance to the general surgeon, yet rare enough for many surgeons not to have had enough cases for study as to their pathogenesis and treatment. There is a widespread opinion that such cases are due to a "tuberculous rib" as the distributing or primary focus. From this study the lungs, pleura and the mediastinal lymphatics seem preëminently responsible. The abscess is frequently deep as well as superficial to the chest wall. The abscesses occur chiefly on the anterolateral aspects of the chest wall rather than posteriorly. The associated tuberculous lesions are varied in number and importance. They may be or may not be more important than the abscesses. An extraordinarily large amount of calcium deposit may be present. Complete excision of the tuberculous focus, leaving vascular, well-nourished walls to come together, is the treatment; this may have to be modified by an associated lesion.